STATE PLAN FOR MEDICAL ASSISTANCE
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

PROGRAM	LIMITATIONS
(Continued) Services that require Preauthorization	1. All personal care cases must be preauthorized based on an assessment of functional capability. 2. Services rendered by one provider to more than two active cases concurrently. 3. Services rendered by one registered nurse to more than 50 active cases concurrently.

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PROGRAM	LIMITATIONS
23.g. Nurse Anesthetist Services	Nurse anesthetist services are provided through the Physicians' Services Program, by reimbursing physicians for the services of nurse anesthetists in their employ. The Program also reimburses nurse anesthetists directly for medically necessary services, performed in collaboration with an anesthesiologist, other licensed physicians, or which require substantial specialized knowledge, judgment, and skill related to the administration of anesthesia, including the assessment of patients before and after operations; administration of anesthetics; monitoring of patients during anesthesia; management of fluid in intravenous therapy; and provision of respiratory care.

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PROGRAM	LIMITATIONS
(Continued) 23. g. Nurse Anesthetist Services	The following are not covered under the Nurse Anesthetist Services regulations: 1. Services not encompassed by the definition of the practice of nurse anesthesia; 2. Services not medically necessary; 3. Services prohibited by the Maryland Nurse Practice Act of by COMAR 10.27.06; 4. Services prohibited in the jurisdiction in which services are provided; and 5. Nurse anesthetist services provided to HMO-MA enrollees. 6. Billing time limitations: a. The Department may not reimburse the claims received by the Program for payment more than 6 months after the date of service. b. Medicare Claims. For any claim initially submitted to Medicare and for which services have been: (i) Approved, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later; and (ii) Denied, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later. c. A claim for services provided on different dates and submitted on a single form shall be paid only if it is received by the Program within 6 months of the earliest date of service.

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PROGRAM	LIMITATIONS
(Continued) 23. g. Nurse Anesthetist Services See Page 9-2	d. A claim which is rejected for payment due to improper completion or incomplete information shall be paid only if it is properly completed, resubmitted, and received by the Program within the original 6 month period, or within 60 days of rejection, whichever is later. e. Claims submitted after the time limitations because of a retroactive eligibility determination shall be considered for payment if received by the Program within 6 months of the date on which eligibility was determined. 7. Nurse anesthetists who are employed by or under contract to any dentist, physician, clinic, HMO, or hospital may not bill for any service for which reimbursement is sought by the dentist, physician, clinic, HMO, or hospital. 8. Nurse anesthetists may not bill the Program for: a. Completion of forms and reports; b. Broken or missed appointments; c. Professional services rendered by mail or telephone; and d. Services which are provided to the general public at no charge.

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PROGRAM		LIMITATIONS
23.g.	Nurse Anesthetist Services (cont.)	g. Payments on Medicare claims are authorized, if: 1. Services are covered by the Program; 2. The provider accepts Medicare assignments; 3. Medicare makes direct payment to the provider; 4. Medicare has determined that the services were medically justified; and 5. Initial billing was made directly to Medicare according to Medicare guidelines. h. Supplemental payments on Medicare claims for services rendered on or after January 1, 1989, are made subject to the following provisions: 1. Deductible insurance will be paid in full; 2. Co-insurance will be paid in full; and 3. Services not covered by Medicare are payable according to g. above.

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PROGRAM		LIMITATIONS
23.h.	Nurse Practitioner Services (cont.)	5. Nurse practitioner services provided to HMO-MA enrollees; 6. Nurse practitioner services included as part of the cost of an inpatient facility, hospital outpatient department, or free-standing clinic; 7. Visits by or to the certified nurse practitioner solely for the purpose of the following: a) Prescription, drug, or food supplement pick-up; b) Collection of specimens for laboratory procedures; c) Recording of an electrocardiogram; d) Ascertaining the patient's weight; or e) Interpretation of laboratory tests or panels; 8. Drugs and supplies which are acquired by the certified nurse practitioner at no cost; 9. Injections and visits solely for the administration of injections, unless medical necessity and the patient's inability to take appropriate oral medications are documented in the patient's medical record; 10. More than one visit per day unless adequately documented as an emergency situation; 11. Services paid under COMAR 10.09.22, Free-Standing Dialysis Facility Services; 12. Audiometric tests for the sole purpose of prescribing hearing aids; 13. Immunizations required for travel outside the continental United States; 14. Acupuncture; 15. Hypnosis; 16. Travel expenses;

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PROGRAM	LIMITATIONS
23.h. Nurse Practitioner Services (cont.)	17. Billing limitations: a. Nurse practitioners shall accept payment by the Program as payment in full for services rendered to eligible recipients and make no aditional charge to any person for covered services. b. Nurse practitioners shall agree that, if the Program denies payment or requests repayment on the basis that an otherwise covered service was not medically necessary or preauthorized, they will not seek payment from the recipient. c. ~~Billing~~ time limitations for claims submitted ~~pursuant~~ to this chapter are set forth in COMAR ~~10.09.36~~. d. Nurse practitioners who are employed by or under contract to any dentist, physician, clinic, HMO, or hospital may not bill for any service for which reimbursement is sought by the dentist, physician, clinic, HMO, or hospital. e. Nurse practitioners may not bill the Program for: 1. Completion of forms and reports; 2. Broken or missed appointments; 3. Professional services rendered by mail or telephone; 4. Services which are provided to the general public at no charge; and 5. Laboratory or x-ray services performed by another facility.

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	PROGRAM	LIMITATIONS
23.h.	Nurse Practitioner Services (cont.)	f. Payments on Medicare claims are authorized, if: 1. Services are covered by the Program; 2. The provider accepts Medicare assignments; 3. Medicare makes direct payment to the provider 4. Medicare has determined that the services were medically justified; and 5. Initial billing was made directly to Medicare according to Medicare guidelines.

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PROGRAM	LIMITATIONS
24. Medical Supplies and Equipment	1. Billing time limitations: a. The Department may not reimburse the claims received by the Program for payment more than 6 months after the date of service. b. Medicare Claims. For any claim initially submitted to Medicare and for which services have been: (i) Approved, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later; and (ii) Denied, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later. c. A claim for services provided on different dates and submitted on a single form shall be paid only if it is received by the Program within 6 months of the earliest date of service. d. A claim which is rejected for payment due to improper completion or incomplete information shall be paid only if it is properly completed, resubmitted, and received by the Program within the original 6 month period, or within 60 days of rejection, whichever is later. e. Claims submitted after the time limitations because of a retroactive eligibility determination shall be considered for payment if received by the Program within 6 months of the date on which eligibility was determined.

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PROGRAM	LIMITATIONS
24. Medical Supplies and Equipment (Cont.)	2. Disposable supplies are not authorized except for: a. Ostomy supplies (other than deodorants and cleaners); b. Supplies for permanent urinary incontinence; c. Blood and urine glucose and urine ketone monitoring supplies; d. Spinal cord dysfunction supplies as described in COMAR 10.09.12.04.B; e. Home kidney dialysis supplies when purchased or rented for Medical Assistance recipients as approved by the Kidney Disease Program. f. Non-invasive osteogenesis stimulator including all follow-up care, batteries, repairs and replacement parts, not to exceed one stimulator for the same fracture, when the following criteria are met: (i) The use is for non-invasive therapy; (ii) The bone fracture is at least 6 months old, except when used for pseudarthrosis; and (iii) The space gap of the fracture measures 1/2 centimeter or less, except when used for pseudarthrosis. Coverage of the osteogenesis stimulator will not continue beyond the first 6 weeks of use unless evaluations at the 6-week and 3-month intervals after initial date of service verify recipient use of at least 50 percent of the time prescribed, each time on a form designated by the Department.